A. OTHER THIRD PARTY LIABILITY (TPL) COVERAGE

The Wisconsin Medical Assistance Program (WMAP) is the payer of last resort for any service covered by the WMAP. If the recipient is covered under third party insurance, the WMAP reimburses that portion of the allowable cost remaining after all other third party sources have been exhausted. Refer to Section IX-D of Part A of the WMAP Provider Handbook for more detailed information on services requiring third party billing, exceptions, and the "Other Insurance Discrepancy Report."

B. MEDICARE/ MEDICAL ASSISTANCE DUAL ENTITLEMENT

Recipients covered under both Medicare and Medical Assistance are referred to as dual-entitlees. Claims for Medicare covered services provided to dual-entitlees must be billed to Medicare prior to billing Medical Assistance. AODA day treatment is not a Medicare-covered service, and thus billing Medicare for dual entitlees is not required. However, a Medicare disclaimer code must be indicated on the claim, if the recipient has Medicare, as indicated in the claim form instructions in Appendix 7 of this handbook.

C. BILLED AMOUNTS

Providers are required to bill their usual and customary charges when rendering an identical service to WMAP recipients and to private pay recipients. Providers must not discriminate against recipients by charging a higher fee for the same service than is charged to a private pay patient.

AODA day treatment assessment and services will be reimbursed based on an hourly rate, per recipient, on the basis of the provider's usual and customary charge or a maximum fee, whichever is less.

Hospitals which are certified AODA day treatment providers must establish a nonreimbursable cost center in their cost reports for this service. As providers, hospitals will be paid by the hour for AODA day treatment according to the maximum allowable fee schedule.

D. CLAIM SUBMISSION

Paper Claim Submission

AODA day treatment services must be submitted using the National HCFA 1500 claim form dated 12/90. A sample claim form and completion instructions can be found in Appendices 7 and 8 of this handbook.

AODA day treatment services submitted on any other form than the National HCFA 1500 claim form will be denied.

The National HCFA 1500 claim form is not provided by the WMAP or EDS. It may be obtained from a number of forms suppliers. One such source is:

State Medical Society Services
Post Office Box 1109
Madison, WI 53701
(608) 257-6781 (Madison area)
1-800-362-9080 (toll-free)

Completed claims submitted for payment must be mailed to the following address:

EDS
6406 Bridge Road
Madison, WI 53784-0002

D. CLAIM SUBMISSION (continued)

Paperless Claim Submission

As an alternative to submission of paper claims, EDS is able to process claims submitted on magnetic tape (tape-to-tape) or through telephone transmission via modem. Claims submitted electronically have the same legal requirements as claims submitted on paper and will be subjected to the same processing requirements as paper claims. Providers submitting electronically can usually reduce their claim submission errors. Additional information on alternative claim submission is available by contacting:

EDS
Attn: EMC Department
6406 Bridge Road
Madison, WI 53784-0009
(608) 221-4746

Submission of Claims

All claims for services rendered to eligible WMAP recipients must be received by EDS within 365 days from the date the service was rendered. Claims for coinsurance and deductible for services rendered to recipients covered by both Medicare and Medical Assistance must be received by EDS within 365 days from the date of service, *or* within 90 days from the Medicare EOMB date, whichever is later. (Refer to Section IX of Part A of the WMAP Provider Handbook for exceptions to the 90-day extension.) This policy applies to all initial claim submissions, resubmissions, and adjustment requests.

E. DIAGNOSIS CODES

All AODA day treatment claims for procedure code W8982 (AODA day treatment) must have a primary diagnosis of one of the following ICD-9-CM (International Classification of Diseases, 9th Edition, Clinical Modifications) codes:

303.9	alcohol dependence
304.0-304.9	drug dependence
305.0	alcohol abuse
305.2-305.9	alcohol and other drug abuse

Claims received without the appropriate ICD-9-CM code will be denied.

The complete ICD-9-CM code book can be ordered from:

ICD-9-CM
Post Office Box 991
Ann Arbor, MI 48106

Providers should note the following diagnosis code restrictions:

- Codes with an "E" prefix must not be used as the primary or sole diagnosis on a claim submitted to the WMAP.

- Codes with an "M" prefix are not acceptable on a claim submitted to the WMAP.

F. PROCEDURE CODES

HCFA Common Procedure Coding System (HCPCS) codes are required on all CSP claims. Claims or adjustments received without HCPCS codes are denied. Allowable HCPCS codes for CSP are included in Appendix 7 of this handbook.

G. FOLLOW-UP TO CLAIM SUBMISSION

It is the responsibility of the provider to initiate follow-up procedures on claims submitted to EDS. Processed claims appear on the Remittance and Status Report either as paid, pending, or denied. Providers are advised that EDS will take no further action on a denied claim until the information is corrected and the claim is resubmitted for processing. If a claim was paid incorrectly, the provider is responsible for submitting an adjustment request form to EDS. Section X of Part A of the WMAP Provider Handbook includes detailed information regarding:

- the Remittance and Status Report
- adjustments to paid claims
- return of overpayments
- duplicate payments
- denied claims
- Good Faith claims filing procedures